BEFORE THE
DEPARTMENT OF CONSUMER AFFAIRS
BOARD OF VOCATIONAL NURSING AND PSYCHIATRIC TECHNICIANS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	Case No. PT-2003-1249
RICHARD LOYD GRAY 285 S. Red Oak Street Porterville, CA 93257	OAH No. 2008060293
Psychiatric Nurse License No. PT 30932	
Respondent.	

DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Board of Vocational Nursing and Psychiatric Technicians as the final Decision in the above-entitled matter.

This Decision shall become effective on March 11, 2009.

IT IS SO ORDERED this 9th day of February, 2009.

John P. Vertido, L.V.N
President

BEFORE THE
DEPARTMENT OF CONSUMER AFFAIRS
FOR THE BUREAU OF VOCATIONAL NURSING
AND PSYCHIATRIC TECHNICIANS
STATE OF CALIFORNIA

In the Matter of the Accusations Against: RICHARD LOYD GRAY Psychiatric Technician License No. PT 30932 JANETTE LYNN CLEMENT Psychiatric Technician License No. PT 24049 LAURINE P. LUCKEY Psychiatric Technician License No. PT 20539 MARK STEVEN REITZEL Psychiatric Technician License No. PT 26367 EDWARD S. SALAZAR Psychiatric Technician License No. PT 19120 Respondents.	Case Nos. PT-2003-1249 PT-2003-1251 PT-2003-662 PT-2003-1252 PT-2003-1253 OAH Nos. 2008060293 2008060294 2008060297 2008060300 2008060301

PROPOSED DECISION

On October 21, October 22 and October 23, 2008, in Porterville, California, Ann Elizabeth Sarli, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter.

Jennifer S. Cady, Deputy Attorney General, represented the complainant.

Ben Aliamano, Attorney at Law, represented respondents Janette Clement and Mark Reitzel.

Steven Bassoff, Attorney at Law, represented respondents Richard Gray, Laurine Luckey and Edward Salazar.

Evidence was received, the record was closed and the matter was submitted on October 23, 2008.

PROCEDURAL FINDINGS

1. The Board of Vocational Nursing and Psychiatric Technicians issued Psychiatric Technician licenses to respondents as follows:

Number PT 19120 to Edward S. Salazar (Salazar) on April 4, 1979. This license expired February 2006 and has not been renewed.

Number PT 20539 to Laurine P. Luckey (Luckey) on October 1, 1980.

Number PT 24049 to Janette Lynn Clement (Clement) a.k.a. Janette Lynn Fischer on August 21, 1985.

Number PT 26367 to Mark Steven Reitzel (Reitzel) on April 19, 1989.

Number PT 30932 to Richard Loyd Gray (Gray) on May 14, 2001.

2. In February 2008, Teresa Bello Jones, Executive Officer, Board of Vocational Nursing and Psychiatric Technicians, made and filed Accusations against respondents, in her official capacity. The Accusations allege that respondents acted below the standard of care in respect to containment of a client on April 13, 2003.

3. Respondents timely filed Notices of Defense. The matters were consolidated for hearing and the matter was set for hearing before an Administrative Law Judge with the Office of Administrative Hearings, an independent adjudicative agency of the State of California, pursuant to Government Code section 11500 et seq.

FACTUAL FINDINGS

1. The Porterville Developmental Center (PDC) is a state-operated facility which serves people with developmental disabilities. Many of the individuals served at PDC have serious medical and/or behavioral problems and require services within a secure treatment program. Many of the clients are in the mild to moderate range of mental retardation and have come in contact with the legal system. The courts have determined them to be a danger to themselves or others and/or incompetent to stand trial. Additionally, the courts have determined that they meet the criteria requiring treatment in a secure area. In 2003, PDC had a population of about 800 clients.

2. When PDC hires psychiatric technicians, it requires them to take Active Treatment Crisis Management Training (ATCM) during orientation.[1] The psychiatric technician must repeat this training yearly. ATCM is a systematic approach to addressing out-of-control behavior. ATCM training is designed to provide the psychiatric technician with techniques for verbal and physical interventions. The goal is to prevent out-of-control behaviors, and if not possible, resolve these situations safely and calmly.

ATCM training provides instruction on safely restraining clients (containment). ATCM teaches a team approach to physical restraint. In 2002 and 2003, the ATCM training instructed that a minimum of two people is required to perform a containment. In the event a containment was necessary, one person should restrain each of the client's arms. Ideally, the heaviest and tallest staff members should secure the arms of large clients. If additional staff were available, these additional persons should restrain the client's legs. If an additional person was available, and the legs and arms were restrained, that person should move to the top of the client's head and get down on one knee and protect the client's head so the client could not bang his head on the floor. This person was to "shadow" the head by placing his hands in a laced cupped position about two inches over the head. If the client lifts his head off the floor he can not gain momentum and bang his head on the floor. The staff that are restraining the client's arms were instructed that they could look away from the client to avoid the client spitting in their eyes. The ATCM training instructs that the safest procedure when there is only one staff person available is to avoid, evade or escape the aggressor until help arrives.

Additionally, the ATCM training instructed that a two-person wall restraint is preferable to a takedown and prone containment. The manual provided to physical therapists instructs as follows:

> **CAUTION!!** Prone containments are the most restrictive of the physical interventions. The process poses potential dangers of injury to both client and staff. As such it should be utilized as a last resort measure after other, less restrictive forms of intervention have failed. A **clear and present danger** of injury must exist and staff must perceive that an <u>immediate</u> threat to safety is present.
>
> THERE ARE <u>NO</u> ONE-PERSON CONTAINMENT PROCEDURES. ALL PHYSICAL INTERVENTIONS THAT REQUIRE CONTAINMENT MINIMALLY UTILIZE TWO – PERSON CONTAINMENT PROCEDURES. THE MAXIMUM NUMBER OF

[1] This training was formerly entitled "Managing Assaultive Behavior (MAB)."

STAFF FOR PRONE PHYSICAL CONTAINMENT IS FIVE. (emphasis in original)

The ATCM training emphasized this material in a manual and in a PowerPoint presentation. Additionally, the staff practiced effective containment procedures during the training. Respondents, who were all PDC employees, received this training on orientation and yearly thereafter. Clement, who was new to PDC, received this training in her orientation and had received it previously in the other facilities in which she had worked.

In addition to their training, respondents were provided with periodic bulletins outlining their responsibilities in behavior management. Respondents were provided Facility Bulletins which set forth the conditions for containment and the prohibition on containment by fewer than two persons.

3. In April 2003, respondents were familiar with ATCM containment procedures, they were aware of the prohibition against one-person containment, and they were aware of the dangers of inappropriate containments, to themselves and clients. Respondents had all participated in multiple containments prior to April 2003.

4. A. M.[2] had been a client of PDC since 1997. Previously, he had been a client of Camarillo State Hospital and Developmental Center until that facility closed in 1997. A.M. was committed to PDC by court order, pursuant to Welfare and Institutions Code section 6500, as a danger to himself and others. A.M. had an IQ of 63, which qualified him as mildly mentally retarded. He was deaf and mute, but was able to read lips. He was also diagnosed with paranoid schizophrenia and had previous psychiatric diagnoses which included antisocial personality disorder and pedophilia. A.M.'s history included incidents involving physical altercations, threats to staff, intimidation, lying, noncompliance and various criminal acts. On May 8, 2002, staff psychologist Clint Soares wrote:

> The combination of this history which includes a variety of dangerous and disturbed behaviors and his periodic severe assaultive and aggressive behavior even in a secure and highly supervised environment and while on antipsychotic medication strongly supports the continued presence in [A.M.] of unacceptably high potential for dangerous behavior... based on his often unpredictable aggressive and assaulted behavior towards either peers or staff, A.M. presents a clear danger to others in his environment.

[2] PDC clients are referred to herein by their initials in order to protect their confidentiality.

A.M. also suffered from hypertension. He was prescribed an antipsycholic medication, quetiapine, and a medication for hypertension, propanolol. In 2003, A.M. resided on unit 17, a secure, forensic unit. He was 37 years old, 6 feet tall and weighed at least 250 pounds. He was very proud of his size and enjoyed demonstrating his strength.

5. On Thursday, April 10, 2003, A.M. refused to take any of his medications. Toward the end of the day, he became upset and aggressive, entered the facility laundry room and refused to leave. Facility police were called and when they arrived A.M. ran down the hall and broke off a door handle while trying to get out of the building. He was placed in restraints and was evaluated by the facility physician Dr. Roberts. Dr. Roberts gave A.M. intramuscular injections of Ativan and Haldol to control symptoms of psychosis. A "crisis review" was conducted. A.M. agreed to take his medications. Staff agreed that if A.M. again refused to take his medications, the nurse practitioner would notify Dr. Roberts and Dr. Roberts would reevaluate A.M., after the weekend. On April 11, 2003 A.M. accepted all his medications. On April 12, 2003, Saturday, A.M. refused all medications the entire day.

6. Gray was on duty that Saturday and notified the nurse practitioner that A.M. was refusing his medications and acting in a bizarre fashion. At one point during the day, A.M. refused to return from the rear courtyard. He would not come in until facility police arrived. That evening, A.M. pushed aside a female staff member and ran out the main door toward the sallyport. Gray and other staff members entered the sally port with facility police officers, and with that show of force, A.M. gave up and came back into the facility. A.M. continued to exhibit agitated behavior by pacing and standing near the front door. He eventually went to sleep at 3 a.m. and slept until noon on Sunday. When he awoke he refused his medications and refused to eat.

7. On Sunday, April 13, 2003, Gray reported for work on the 6:30 a.m. to 3:00 p.m. shift. Staff had advised him to enter the unit through an alternate door because A.M. had been monitoring the entrance door for an opportunity to escape when someone entered. The staff assigned to unit 17 on April 13, 2003, were Gray, Clement, Luckey, Remy Ocampo, Randy Burton and Salazar. At around 12:30 p.m. Burton and Salazar left the unit to escort clients to the snack bar. Luckey had escorted a client to the showers and was returning to the unit's technician station. Gray, Clement and Ocampo were in the technician station. Clement was the med-person, in charge of dispensing medications. She was in the back of the technician station, in the "med room," working on charts.

8. A.M. was continuing to pace in the hallway outside the technician station. Ocampo had just gone out the right door of the technician station and was holding her keys in her hand to lock the technician station door when A.M. grabbed Ocampo's keys. Gray heard Ocampo scream "Rick, he has my keys!" or words to that effect. Gray ran out the right door of the technician station and saw that A.M. was

holding a restraint key and was attempting to stab Ocampo. Ocampo was backing up against the wall holding her stomach. The restraint key is a key with a knife-like appearance approximately one and a half to two inches long with a shaft ending in a point. Gray told A.M. to give him the keys. A.M. tried to stab Gray with the restraint key. Gray backed away and sounded his alarm, summoning help from adjacent units. At this point, Luckey was coming up the hall. Gray told Ocampo, Luckey and Clement to go into the technician station and lock the door. Clement, Ocampo and Luckey stayed in the technician station until other staff arrived several minutes later.

9. Meanwhile, A.M. had walked toward another client, V.M., who was sweeping the floor with a push broom. V.M. was approximately 6 feet tall and close to 300 pounds. A.M. stabbed V.M. with the restraint key, in V.M.'s arm, chest and side. A.M. then turned and headed down the other end of the hallway toward another client K.B. K.B. had seen A.M. stab V.M. and as A.M. approached K.B., K.B. hit A.M. in the head. K.B. was also a large man, approximately six foot four inches tall and weighing close to 300 pounds. A.M. turned around and started walking up the hallway back towards the technician station.

10. As A.M. approached the technician station Gray confronted A.M. in the hallway. A.M. attempted to hit Gray and tore his shirt. A.M. turned back down the hallway and Gray followed him, with V.M close behind. K.B.came up to A.M. and hit him two more times with uppercut punches. Gray was concerned that K.B. and V.M, who were both large men, would seriously hurt A.M. Gray was also concerned that A.M. would continue to stab staff and clients with the restraint key. Gray jumped on A.M.'s back, with his right arm around A.M.'s shoulders. Gray used his left hand to ward off K.B. A.M. who was taller and heavier than Gray, bent over at the waist under the weight of Gray. Gray's feet came off the ground. The two became unbalanced and fell to the floor.

When they hit the floor, Gray remained on A.M.'s back. Gray's entire body lay on A.M. K.B. came around to the front of the two and attempted to pick up A.M.'s head to smash it on the ground. Gray protected A.M.'s head by placing his right arm under A.M.'s left ear, so that Gray's arm was between A.M.'s head and the floor. A.M.'s head was turned to the right and Gray could see him breathing. Gray tried to communicate to him that he needed to calm down. A.M. tried to bite Gray's bicep and Gray moved his right arm so that A.M.'s chin was on top of Gray's elbow. A.M. was struggling to arise and was trying to throw Gray off his back.

Gray was lying on the floor with his body lying full length on A.M.'s back and with his right arm under A.M.'s head for about two minutes when Burton and Reitzel arrived in response to the alarm. Gray remained lying on A.M.'s back, with his right arm around A.M.'s neck and Gray's right hand holding his own left hand. Gray told Reitzel to get the keys from A.M. Reitzel wrestled the keys from A.M.s right hand. Reitzel then grabbed A.M.'s right arm, turned toward the wall and held A.M.'s right arm in place, in the manner prescribed in the ATCM protocols. Burton

grabbed the left arm and faced into the hallway, in the manner prescribed in the ATCM protocols. Salazar arrived and grabbed A.M.s right leg, also in the manner prescribed in the ATCM protocols. Either client V.M. or another staff member grabbed the other leg. Gray called out for restraints and remained on A.M.'s back while Luckey delivered the restraints and assisted in placing the leg restraints on A.M. A.M. continued to try to throw Gray off his back. Facility police officers arrived on the scene. An arm restraint was placed on A.M.'s left wrist.

The staff attempted to pass the arm restraints from A.M.'s left wrist to the right wrist while Gray remained lying on top of him. Gray pulled up on A.M. to allow the restraints to pass underneath A.M., from his left to his right side. At this point, Gray noticed that A.M. had stopped struggling. Gray got off A.M.. Gray had been lying on A.M.'s back for five to seven minutes. A.M. was rolled over and was not breathing. CPR was initiated. A.M. was transported to Sierra View Hospital where he was pronounced dead.

11. An autopsy was conducted by Gary A. Walter M. D. on April 15, 2003. Dr. Walter established the cause of death as "cardiac dysrhythmia due to prolonged left carotid artery compression." Dr. Walter commented that "the cause of death appears to include an element of asphyxia with vagal inhibition." Dr. Walter noted that "there is a region of left supra-thyroid soft tissue hemorrhage overlying the inferior larynx/superficial trachea in this region." He also noted that "the left mid carotid artery showed a region of surrounding soft tissue hemorrhage." The Deputy Coroner concluded that "decedent expired as a result of Porterville Developmental Center staff attempting to restrain him during assaultive and combative behavior and his death is classified as accidental."

Allegations Against Gray

12. The Accusation alleges that Gray's actions in containing A.M. were incompetent, grossly negligent and constituted excessive force, mistreatment and abuse of A.M. Complainant offered persuasive expert opinion that Gray's action in attempting a one-person containment was in violation of ATCM training and that the standard of care for psychiatric technicians is to follow ATCM protocols. Expert opinion established that Gray substantially departed from the standard of care ordinarily possessed by and exercised by a reasonable licensed psychiatric technician by: (1) jumping on A.M.'s back; (2) remaining on A.M.'s back for five to seven minutes; and (3) placing his right arm under A.M.'s neck.

Gray contends that he had no choice but to jump on A.M.'s back in order to protect him from approaching angry clients and to prevent A.M. from stabbing other people with the keys he was brandishing. A.M. could have seriously injured someone with the keys. Gray believed he was alone in addressing the crisis, as he had only small women on his unit at the time and he believed they could not contain A.M. He understood that it might take a few minutes for staffers to arrive from other units to

assist in a containment and felt he had to take action. He felt he could not try to talk to A.M. because he was deaf and could not safely get into a position in front of A.M. because he would be between A.M. and his attacker K.B.

The evidence is persuasive that Gray acted rashly, impulsively and with poor judgment in jumping on A.M.'s back. He ignored the ATCM protocols and ignored the fact that Clement and Luckey were also trained in ATCM protocols. He should have asked for Clement's and Luckey's assistance. The evidence is that Gray had activated his alarm and he could count on other staff to assist him in a minute or so.

Even if Gray had acted appropriately in jumping on A.M.'s back, remaining on A.M.'s back for several minutes after Reitzel and Salazar arrived and secured A.M.'s arms was grossly negligent, incompetent and constituted excessive force. At hearing, Gray offered the explanation that he was unable to get off A.M.'s back without stepping on Reitzel or Salazar. Gray was not credible. The evidence is persuasive that Gray remained "pancaked" on A.M.'s back without making any attempt to rise, in an effort to keep him down on the floor, even after facility police had arrived. Further, Gray's action of keeping his right arm around A.M.'s neck during the entire containment was grossly negligent, incompetent and constituted excessive force. Gray testified that his arm did not put pressure on A.M.'s airway or throat and that Gray supported his own body weight with his elbows to avoid putting pressure on A.M. This testimony was not credible. It is not credible that Gray could maintain a position lying lengthways on A.M.'s back, with his right arm around A.M.'s head and neck area, and support his weight with his elbows. The witness statements do not support Gray's testimony, and the autopsy report identifies hemorrhaging at the inferior larynx/ superficial trachea and the left mid carotid artery, the areas where A.M.'s head and neck came in contact with Gray's right arm.

While the evidence is clear that Gray's actions in jumping on A.M.'s back, remaining on his back and placing his right arm around Gray's neck were grossly negligent, incompetent and constituted excessive force, the evidence is also clear that Gray had no malice toward A.M. and had no intent to harm him. Rather, Gray's intentions, however misguided, were to protect A.M., the staff and other patients.

Allegations Against Reitzel

13. The Accusation alleges that when Reitzel arrived on the scene, he saw Gray lying on A.M.'s back with his arm around A.M.'s neck. He also saw that A.M. was struggling. The Accusation alleges that Reitzel should have recognized that Gray was not using an approved ATCM containment procedure and should have intervened to ensure that proper containment procedures were followed. The Accusation alleges that Reitzel's failure to intervene constituted gross negligence, incompetence and constituted use of excessive force, mistreatment and abuse of A.M.

Complainant offered persuasive expert opinion that Reitzel substantially departed from the standard of care ordinarily possessed by and exercised by a reasonable licensed psychiatric technician when he did not advise Gray to get off A.M.'s back and neck or suggest an alternate method of containment which complied with ATCM protocols. Complainant did not prove that Reitzel, himself, used excessive force or mistreated or abused A.M.

The Accusation further alleges that Reitzel committed acts of dishonesty in his interviews with investigators following the incident. It is alleged that Reitzel gave "inconsistent and different versions" of the position he was in and the position Gray was in during the containment of client A.M., and that his account was "in total opposition to the account of events by PT Gray."

At the outset, it is recognized that Reitzel's version of the respective positions of himself and Gray during the containment of A.M. were in conflict. The fact that Reitzel's account was "in total opposition to the account..." given by Gray, or anyone else, does not, in itself, constitute grounds for an allegation of dishonesty. The fact that their statements were in conflict does not mean that Reitzel was dishonest. The inquiry here is whether Reitzel's statements to investigators were dishonest.

Reitzel was interviewed on April 30, 2003, by two investigators, Robert Friedman, Senior Special Investigator with the Department of Developmental Services and Special Investigator Joe Baumgardner, who was employed by with PDC. Reitzel had a union representative accompany him. Reitzel was advised he was being questioned as part of an official investigation and he was directed to answer all questions honestly and completely. He was advised that his refusal to answer, or any type of evasion, deception, dishonesty or lack of cooperation could constitute insubordination and/or inexcusable neglect of duty and result in disciplinary action up to and including dismissal from his employment. He was advised that his statements and the evidence gained by reason of his statements could not be used in a criminal proceeding. Reitzel agreed that he understood the advisements.

Reitzel related that he arrived on unit 17 about a minute to a minute and a half after he heard the alarm. Luckey met him at the door to unit 17 and pointed down the hallway. There he saw a couple of clients and Gray on the floor with A.M. There were no other staff members there. Reitzel told investigators that A.M. was lying on his right side with his right hand tucked under his body. Reitzel had to dig the keys out of A.M.'s right hand. Reitzel told investigators that Gray was not on top of A.M. and was not lying on A.M.'s back. He demonstrated Gray's position with Gray crouched on his knees over A.M.'s head, with his hands securing A.M.'s head. Reitzel said he did not see where Gray's arms were in relation to A.M.'s head. As soon as Reitzel got the keys from A.M. he grasped A.M.'s right arm, secured it, and looked away from A.M. so that A.M. could not spit on him. He assumed that other people secured A.M.'s left arm and legs because A.M. was moved from his right side into a prone position.

During his interview, Reitzel conceded that Gray could have gotten on A.M.'s back after Reitzel secured A.M.'s right arm. However, Reitzel stated he would not have seen Gray get on A.M.'s back because Reitzel's face was turned away from A.M. Later in the interview, Reitzel stated that when he first got to the scene he "wasn't especially looking to see where this person [Gray] was in particular." He again acknowledged that Gray could have gotten onto A.M.'s back when they had gone into prone containment, but he did not see that and "wasn't aware of the particulars of what Rick was particularly doing."

Later in the interview, Reitzel was told that his recollection of where Gray was when he arrived on the scene was inconsistent with other accounts. He was "given an opportunity to think about it." Reitzel then explained and described Gray's position. Gray's body was positioned over A.M.'s body so that "he would have had to have his side possibly on top of him coming around the front - to the head." He also described Gray's arms as tucked up underneath A.M.'s head with the hand of one arm grabbing the wrist of the other. Gifford then asked him, "Is it true that when you walked onto the unit and assessed the situation Rick [Gray] was at the head as you described originally?" Reitzel responded, "Well, when I say he was at the head, I mean he was in front of the head and the head area and the upper body and the shoulders across the back." "He may have been more around him than I stated before." When asked what he meant by "around," he stated, "Well, more wrapped around his head area." Later, after investigators told Reitzel that this was a death investigation and a serious matter, they asked him "Isn't it true that Rick was never up in that position by his head the way you described it earlier?" After clarifying the question, Reitzel answered "yes" and "I want to help you out here."

At hearing, Reitzel testified that when he arrived on the scene he saw Gray, not on A.M.'s back, but holding his head in the position he described in his statement. He explained that he had been badgered during the interview, was exhausted, and was just trying to give the investigators what they wanted. A reading of the transcript of the investigational interview confirms that Reitzel was repeatedly questioned and his version of events was continuously challenged by the investigators. The transcript demonstrates Reitzel's halfhearted agreement with investigators that he had not seen Gray crouched by A.M.'s head when he arrived at the scene. However, the transcript also reveals Reitzel's evasiveness during the entire interview. Further, Reitzel's description of Gray's position when Reitzel arrived on the scene is simply not credible, and it is not credible that Reitzel could have been mistaken. Reitzel stated that A.M. was struggling to get up when Reitzel arrived. Yet he also stated that Gray was crouched by A.M.'s head and there were clients at A.M.'s feet. It is not credible that A.M. would have needed to struggle to get up if Gray had been standing, crouched over his head, with clients at his feet. Later, Reitzel indicated Gray was actually holding A.M.'s head, and it is also not credible that this restraint alone, with clients holding the feet, would have kept A.M. on the ground.

Further, at hearing, Reitzel was asked if he ever saw Gray on A.M.'s back. He responded that "when we were getting off [A.M.] and I turned he [Gray] was getting off the back so at some point I assume he was on [A.M.'s] back." This response is in sharp contrast to his statements during the interview that he never saw Gray on A.M.'s back or even felt his presence there.

Finally, the evidence is clear that Gray was on A.M.'s back during the entire containment, and not crouched over A.M.'s head. It is not credible that Reitzel did not see that.

Allegations Against Salazar

14. The Accusation alleges that when Salazar arrived on the scene, he saw Gray lying on A.M.'s back with his arm around A.M.'s neck. He also saw that A.M. was struggling. The Accusation alleges that Salazar should have recognized that Gray was not using an approved ATCM containment procedure and should have intervened to ensure that proper containment procedures were followed. The Accusation alleges that Salazar's failure to intervene constituted gross negligence, incompetence, use of excessive force, mistreatment and abuse of A.M.

In his statement to investigators, Salazar admitted that he saw Gray on A.M.'s back with his arm around A.M.'s neck. Complainant offered persuasive expert opinion that Salazar substantially departed from the standard of care ordinarily possessed by and exercised by a reasonable licensed psychiatric technician when he did not advise Gray to get off of A.M.'s back and neck or suggest an alternate method of containment which complied with ATCM protocols. Complainant did not prove that Salazar, himself, used excessive force or mistreated or abused A.M.

Allegations Against Clement

15. The Accusation alleges that when Clement heard Gray sound the alarm she remained in the technician station until other staff members responded to the alarm. The Accusation alleges that she did not assist Gray by responding to the alarm, as required by PDC policies and procedures and her training as a psychiatric technician. After several minutes, Clement went down the hall and saw Gray on top of A.M. with his arm around A.M.'s neck. The Accusation alleges that Clement should have recognized that Gray was not using an approved ATCM containment procedure and she should have intervened to ensure that proper containment procedures were followed. The Accusation alleges that Clement's failure to intervene constituted gross negligence and incompetence.

Complainant offered expert opinion that Clement substantially departed from the standard of care ordinarily possessed by and exercised by a reasonable licensed psychiatric technician when she stayed in the technician station and did not assist Gray with A.M. She further substantially departed from the standard of care when

she did not advise Gray to get off of A.M.'s back and neck or suggest an alternate method of containment which complied with ATCM protocols.

Respondents offered expert testimony to the effect that Clement used her time "appropriately" by calling for assistance and then walking down the hall to ask Gray whether he needed a restraint order. Respondents' expert also offered the opinion that Luckey and Clement, because of their small stature and light weight, might not have been useful in holding A.M.'s arms down in the containment, although they could have assisted in holding A.M.'s legs down.

The evidence is persuasive that Clement was trained to assist in situations like the one that presented here, and that she had a duty to assist Gray. She could have assisted in a variety of ways to attempt to diffuse the situation, or if necessary, assist Gray in containing A.M. in a safe manner. Clement substantially departed from the standard of care when she failed to assist in the safe handling and containment of A.M. The evidence is persuasive that Clement substantially departed from the standard of care by failing to tell Gray to get off A.M.'s back or suggest an alternate method of containment which complied with ATCM protocols.

The Accusation also alleges that Clement committed acts of dishonesty during interviews with investigators, in that she gave inconsistent and different versions of what occurred and her rendition was in total opposition to the account of events given by Gray and others present. Clement, in her statement to investigators on a May 5, 2003, stated that after help arrived and she knew that A.M. was probably contained, she walked down the hall to ask whether they needed an order from the physician for placement of restraints. She was not "paying a lot of attention" to who was positioned where, and she remembers Gray being on A.M.'s left side "but I don't remember if he was laying across his back or not." Gray then told her to get the restraint order. There was no direct evidence to impeach Clement's assertion that she could not tell who was positioned where. But, the inference can properly be drawn that because Clement actually spoke with Gray when he told her to get a restraint order, she must have seen where he was positioned, and he was on A.M.'s back. For these reasons, the evidence is persuasive that Clement was dishonest in her statement to investigators.

Allegations Against Luckey

16. The Accusation alleges that when Luckey heard Gray sound the alarm, rather than assist a coworker by responding to the alarm as is required by PDC policies and procedures and her training as a psychiatric technician, she retreated to the technician station. She remained in the technician station until other staff members responded to Gray's alarm. She opened the door to the technician station and heard someone tell her to bring the restraints. She brought the restraints and assisted in putting them on A.M.'s legs. The Accusation alleges that Luckey should have communicated with fellow staff members on an appropriate containment

procedure and strategy for containing A.M. and that she failed to follow PDC policies and training in that she neglected to perform her duty to protect the safety and welfare of A.M. The Accusation alleges that Luckey's failure to intervene constituted gross negligence and incompetence.

Complainant offered expert opinion that Luckey substantially departed from the standard of care ordinarily possessed by and exercised by a reasonable licensed psychiatric technician when she stayed in the technician station and did not assist Gray with A.M. The evidence is persuasive that Luckey was trained to assist in situations like the one that presented here and that she had a duty to assist Gray. She could have assisted in a variety of ways to attempt to diffuse the situation, or if necessary, assist Gray in containing A.M. in a safe manner. Luckey substantially departed from the standard of care when she failed to assist in the safe handling and containment of A.M. The evidence is persuasive that Luckey also substantially departed from the standard of care by failing to tell Gray to get off A.M.'s back or suggest an alternate method of containment which complied with ATCM protocols.

Respondents offered expert testimony to the effect that Luckey used her time "appropriately" in the technician station, bringing Ocampo into the technician station, calling for assistance, and then bringing restraints to the scene of the containment and applying them to A.M.'s legs. Respondents' expert also offered the opinion that Luckey and Clement, because of their small stature and light weight, might not have been useful in holding A.M.'s arms down in the containment. However, he testified on cross examination that they could have assisted in holding A.M.'s legs down. The evidence is persuasive however that Luckey should have acted according to her ATCM training. Instead she retreated to the technician station and stayed there out of fear. Rather than leaving Gray alone with A.M., she should have worked with Gray and Clement to form a plan to handle A.M. safely until help arrived.

The Accusation also alleges that Luckey committed acts of dishonesty during interviews with investigators, in that she gave inconsistent and different versions of what occurred and her rendition was in total opposition to the account of events given by Gray and others. Luckey, in her statement to investigators on a May 1, 2003, said that she never saw Gray on A.M.'s back. She said that, initially, Gray told her to take Ocampo into the technician station. When she tried to exit the technician station, Gray told her to get back inside. She stayed inside the technician station and when she heard a loud boom she called the facility police. She did not get through immediately and had to call again. She finally reached the operator and told the operator they needed help on unit 17. When other staff arrived in answer to Gray's alarm, Luckey opened the technician station door and looked down the hall. When she looked down the hall Gray yelled to her to get the restraints and she noticed that Gray was standing. When she brought the restraints A.M. was on his stomach on the floor. She told investigators she did not know where Gray was but that he was "down there somewhere. I don't know where. At least I think he was. I didn't -- I don't know." A. M. was struggling while she was trying to put the restraints on him. She

stated that she had asked everyone where Gray was when she began putting on leg restraints because she wasn't sure where he was and she couldn't really see where he was. People kept saying "there" and she asked "where?" She stated that there were so many people around that she was not sure where Gray was.

The evidence is persuasive that Luckey was dishonest in her responses to the investigators when she told them she did not know where Gray was and did not see him on top of A.M. It is not credible that she could have struggled with placing leg restraints on A.M. for several minutes and not seen Gray lying on top of A.M. Indeed, Gray's legs, although shorter than A.M.'s, would have been in the area around where Luckey was applying the restraints.

Because the evidence is persuasive that Luckey saw Gray on top of A.M, the evidence is persuasive that Luckey substantially departed from the standard of care by failing to advise Gray to get off A.M.'s back or suggest an alternate method of containment which complied with ATCM protocols.

Factors in Justification, Mitigation, Aggravation and Rehabilitation

17. As set forth above, respondents have subjected their psychiatric technician licenses to discipline. However, in consideration of what, if any, discipline should be imposed, licensees may introduce evidence of extenuating circumstances. Licensees may introduce evidence which tends to show justification and mitigation, as well as evidence of rehabilitation. (*Arneson v Fox* (1980) 28 Cal 3d 440, 449). Complainant may introduce evidence of aggravation.

18. In aggravation, A.M. died as a result of improper containment. Also in aggravation is the fact that respondents acted in complete disregard of their training and professional standards. Also in aggravation, in respect to Reitzel, Clement and Luckey, is the fact that they were evasive and lacked candor in their statements to investigators. All the respondents, with the exception of Salazar who did not appear, were less than candid at hearing as well. Reitzel, Clement and Luckey maintained that they did not see Gray lying on top of A.M. Gray contradicted his statements to investigators, in an effort to minimize his responsibility. For instance, he testified that he never jumped on A.M.'s back. In his statement to investigators, he clearly described the fact that he jumped onto A.M.'s back and he introduced that phrase into the conversation. In his statements to investigators, he admitted he had been lying on A.M.'s back the entire time of the containment. During testimony at hearing he began to speak in terms of lying on the right side of A.M.'s body.

19. There are multiple extenuating circumstances that contributed to A.M.'s improper containment and resulting death. Foremost is the failure of medical personnel at PDC to respond to staff notification that A.M., a dangerous and psychotic client, was not taking his antipsychotic medication. The problem was complicated by the fact that unit 17 housed some of the largest and heaviest clients,

who were also the most combative. That unit was staffed with three women who weighed less than 125 pounds, two of whom were over 60 years old. Another extenuating circumstance is the fact that A.M. was deaf and mute, and it was therefore very difficult to reason with him. It was only natural, in the situation that unfolded here, for staff to fear for their own safety. All of these factors mitigate the fact that Gray attempted to contain A.M. himself, and mitigate the fact that Clement and Luckey did not discuss or participate in a proper containment. These factors do not, however, mitigate the fact that Gray remained on A.M.'s back when staff began arriving, and the keys were removed from A.M., and they do not mitigate the fact that Clement, Luckey, Reitzel and Salazar did not intervene at that point for A.M.'s safety.

20. Salazar did not appear and did not introduce any evidence of rehabilitation. His psychiatric technician license expired in 2006 and has not been renewed.

21. In respect to rehabilitation, the Accusations were filed against respondents almost five years after the death of A.M. There was no evidence that respondents had any prior or subsequent discipline action taken by the board. Luckey, Clement, Reitzel and Gray have continued to work as psychiatric technicians since that time. Luckey retired from PDC, with disciplinary charges pending, but was retained as a retired annuitant and has been working part time at PDC. Clement took a psychiatric technician position with the Department of Corrections and Rehabilitation. Reitzel and Gray remained at PDC after a period of suspension. Witnesses testified on behalf of these respondents, affirming that they are conscientious and effective in the performance of their duties. All continue to take regular yearly training on ATCM and effective intervention techniques. Due to the delay in filing the Accusations, respondents have had the opportunity to demonstrate a five and a half year period of compliance with statutes and regulations governing the practice of psychiatric technicians and compliance with the rules and regulations of the facilities in which they work.

Costs

22. Complainant submitted costs certifications in the following amounts:

Gray - $16,107.50 comprised of the legal work of three attorneys and other staff from January 25, 2005, to the date of the hearing and totaling 96.5 hours of work in 2005, 56 hours of work in 2008 and 29 hours of work in 2007, including 17 hours of pleading preparation. Complaint also offered a cost certification for investigative services in the sum of $2,897.50 (1.5 hours at $144 per hour and 15.5 hours at $173 per hour.)

Clement - $13,733 comprised of the legal work of three attorneys and other staff from January 25, 2005, to the date of the hearing totaling over 84 hours of legal work. Complainant also offered a cost certification for investigative

services in the sum of $3070.50 (1.5 hours at $144 per hour and 16.5 hours at $173 per hour).

Luckey- $12,555.75 comprised of the legal work of three attorneys and other staff from August 30, 2006, to the date of the hearing totaling over 73 hours of legal work.

Reitzel- $14,720.50 comprised of the legal work of three attorneys and other staff from February 17, 2005, to the date of the hearing totaling over 96 hours of legal work. Complainant also offered a cost certification for investigative services in the sum of $2,551.50 (1.5 hours at $144 per hour and 13.5 hours at $173 per hour).

Salazar- $10,925.50 comprised of the legal work of three attorneys and other staff from January 25, 2005, to the date of the hearing totaling over 71 hours of legal work. Complainant also offered a cost certification for investigative services in the sum of and investigative services in the sum of $3,344.50 (one hour at $144 per hour and 18.5 hours at $173 per hour)

The entire cost bill for investigation and prosecution of the case against all respondents is $79, 906.25.

LEGAL CONCLUSIONS

1. Business and Professions Code[3] section 4520 provides that the Board may discipline any licensed psychiatric technician for any reason provided in Article 3 (commencing with section 4520) of the Psychiatric Technicians Law. Section 4521, provides:

> The board may suspend or revoke a license issued under this chapter [The Psychiatric Technicians Law (section 4500 et seq.)] for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual psychiatric technician functions.
>
> [¶...¶]

[3] All statutory references are to the California Business and Professions Code unless otherwise indicated.

(j) The use of excessive force upon or mistreatment or abuse of any patient...

[¶...¶]

(n) The commission of any act involving dishonesty, when that action is substantially related to the duties and functions of the licensee.

2. California Code of Regulations, title 16, section 2577, states:

As set forth in Section 4521 of the code, gross negligence is deemed unprofessional conduct and is grounds for disciplinary action. As used in Section 4521 "gross negligence" means a substantial departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent licensed psychiatric technician, and which has or could have resulted in harm to the consumer. An exercise of so slight a degree of care as to justify the belief that there was a conscious disregard or indifference for the health, safety, or welfare of the consumer shall be considered a substantial departure from the above standard of care.

3. California Code of Regulations, title 16, section 2577.1, states:

As set forth in Section 4521 of the code, incompetence is deemed unprofessional conduct and is grounds for disciplinary action. As used in Section 4521, "incompetence" means the lack of possession of and the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by responsible licensed psychiatric technicians.

4. California Code of Regulations, title 16, section 2576.5, sets forth multiple responsibilities of a licensed psychiatric technician. In pertinent part, this section provides:

The licensed psychiatric technician performs services requiring technical and manual skills which include the following:

(a) Uses and practices basic assessment (data collection), participates in planning, executes interventions in accordance with the care plan or treatment plan, and contributes to evaluation of

individualized interventions related to the care plan or treatment plan.

(b) Provides direct patient/client care by which the licensee:

(1) Performs basic nursing services as defined in subdivision (a):

[¶...¶]

(3) Applies communication skills for the purpose of patient/client care and education...

[¶...¶]

5. California Code of Regulations, title 16, section 2576.6, states in pertinent part:

(a) A licensed psychiatric technician shall safeguard patients'/clients' health and safety by actions that include but are not limited to the following:

[¶...¶]

(3) Performing services in accordance with Section 125.6 of the Business and Professions Code.

(b) A licensed psychiatric technician shall adhere to standards of the profession and shall incorporate ethical and behavioral standards of professional practice which include but are not limited to the following:

(1) Maintaining current knowledge and skills for safe and competent practice;

[¶...¶]

(c) A violation of this section constitutes unprofessional conduct for purposes of initiating disciplinary action.

Violations by Gray

6. As set forth in Factual Findings 1 through 12, Gray is subject to disciplinary action under section 4521, subdivision (a) (1), as defined by California

Code of Regulations, title 16, sections 2576.5, 2576.6, 2577 and 2577.1, on the grounds of incompetence and gross negligence.

7. As set forth in Factual Findings 1 through 12, Gray is subject to disciplinary action under section 4521, subdivision (i) on the grounds he used excessive force upon client A.M.

Violations by Reitzel

8. As set forth in Factual Findings 1 through 11 and 13, Reitzel is subject to disciplinary action under section 4521, subdivision (a) (1), as defined by California Code of Regulations, title 16, sections 2576.5, 2576.6, 2577 and 2577.1, on the grounds of incompetence and gross negligence.

9. As set forth in Factual Findings 1 through 11and 13, Reitzel is subject to disciplinary action under section 4521, subdivision (n),[4] on the grounds of dishonesty.

10. As set forth in Factual Findings 1 through 11and 13, Reitzel is not subject to disciplinary action under section 4521, subdivision (i) (abuse/excessive force). This allegation is dismissed.

Violations by Salazar

11. As set forth in Factual Findings 1 through 11 and 14, Salazar is subject to disciplinary action under section 4521, subdivision (a) (1), as defined by California Code of Regulations, title 16, sections 2576.5, 2576.6, 2577 and 2577.1, on the grounds of incompetence and gross negligence.

12. As set forth in Factual Findings 1 through 11 and 14, Salazar is not subject to disciplinary action under section 4521, subdivision (i) (abuse/excessive force). This allegation is dismissed.

Violations by Clement

13. As set forth in Factual Findings 1 through 11 and 15, Clement is subject to disciplinary action under section 4521, subdivision (a)(1), as defined by California Code of Regulations, title 16, sections 2576.5, 2576.6, 2577 and 2577.1, on the grounds of incompetence and gross negligence.

[4] At hearing, the Accusations were amended to correct references to Business and Professions Code section 4521, subdivision (m), to subdivision (n).

14. As set forth in Factual Findings 1 through 11 and 15, Clement is subject to disciplinary action under section 4521, subdivision (n), on the grounds of dishonesty.

Violations by Luckey

15. As set forth in Factual Findings 1 through 11 and 16, Luckey is subject to disciplinary action under section 4521, subdivision (a) (1), as defined by California Code of Regulations, title 16, sections 2576.5, 2576.6, 2577 and 2577.1, on the grounds of incompetence and gross negligence.

16. As set forth in Factual Findings 1 through 11and 16, Luckey is subject to disciplinary action under section 4521, subdivision (n), on the grounds of dishonesty.

Disciplinary Considerations

17. The purpose of disciplinary proceedings is not to punish licensees, but to protect the public. The death of A.M. was a grave and tragic consequence of respondents' failures to follow established containment procedures. But, as set forth in Findings 17 through 21, there was sufficient evidence of mitigation and rehabilitation, particularly the passage of five and one half years without incident, to indicate that Gray, Clement, Luckey and Reitzel no longer pose a risk to clients. However, the findings of dishonesty and the continued lack of candor at hearing that these respondents displayed, indicates a lack of complete rehabilitation. It is thus in the best interest of the public that these respondents serve a probationary period under terms and conditions designed to protect the public.[5]

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[5] This determination is in accord with the guidance provided by California Code of Regulations, title 16, section 2524 and section 2579.10, which provide in pertinent part:

In reaching a decision on a disciplinary action under the Administrative Procedure Act (Government Code section 11400 et seq.) the Board shall consider the disciplinary guidelines entitled "Disciplinary Guidelines", (Rev. 6/19/07), which are hereby incorporated by reference. Deviation from these guidelines, including the standard conditions of probation, is appropriate where the Board, in its sole discretion, determines that the facts of the particular case warrant such a deviation - for example, the presence of mitigating factors; the age of the case; evidentiary problems.

In determining whether revocation, suspension or probation should be imposed in a given disciplinary action, the following factors should be considered:

Nature and severity of the act(s), offense(s), or crime(s) under consideration.

Actual or potential harm to the public.

Actual or potential harm to any patient.

Overall disciplinary record.

18. Although the factors in mitigation apply to Salazar as well, Salazar did not produce evidence of rehabilitation. Thus, Salazar has failed to demonstrate that he does not continue to pose a risk to clients. Salazar's license is expired. However, section 118, subdivision (b), provides that expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated. Under section 4545, the Board may renew an expired license at any time within four years after the expiration.

Assessment of Costs

19. As set forth in Finding 22, the total cost of investigation and prosecution of this matter was established as $79,906.25. Section 125.3 provides in pertinent part that the Administrative Law Judge may direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case. Accordingly, the initial inquiry is whether these costs are reasonable.

Complainant represents that the billing was distributed among the respondents on the basis of work done in connection with the charges against the various respondents. Nevertheless, some of the charges appear excessive and appear to overlap. For instance, the investigative charges total almost $12,000, yet the bulk of the investigation was conducted by investigators for PDC and the Department of Developmental Services in connection with actions by the employer. Complainant's investigator reviewed the extensive investigation record and prepared his own reports, visited the site on one occasion and conducted limited interviews.

Overall criminal actions taken by any federal, state or local agency or court.

Prior warnings on record or prior remediation.

Number and/or variety of current violations.

Mitigation evidence.

In case of a criminal conviction, compliance with terms of sentence and/or court-ordered probation.

Time passed since the act(s) or offense(s) occurred.

If applicable, evidence of proceedings to dismiss a conviction pursuant to Penal Code section 1203.4.

Cooperation with the Board and other law enforcement or regulatory agencies.

Other rehabilitation evidence.

The cost certifications also indicate that multiple attorneys worked on preparing this matter for hearing. There appears to be an overlap in preparation in that as new attorneys were assigned, they were required to become acquainted with the case and state of the evidence. Additionally, there appears to be significant overcharges in certain areas of the billing. For instance, although the pleading in this matter was almost identical for each of the five respondents, the billing indicates a charge for at least 10 hours of work preparing the pleading, for each respondent, and 16 hours for preparing the pleading against Gray.

The total cost of close to $80,000 is patently excessive given that: the investigation undertaken in this matter was conducted in large part by other agencies; this matter was prepared and reviewed multiple times over three years, by three different attorneys; and although there were five respondents, there was only one incident at issue.

Accordingly, the reasonable costs of investigation and prosecution of these matters is modified as follows:

Only the attorney's fees incurred by Jennifer Cady were considered as legal fees. This reduced the legal fees to the following:

Gray:	$11,613
Clement:	$11,060
Luckey:	$9,322
Reitzel:	$11,771
Salazar:	$8,176

Further, the legal fees are reduced by 20% in an attempt to account for some of the areas where billing appears excessive for the task undertaken and/or overlaps other charges.

Gray:	$9,303
Clement:	$8,848
Luckey:	$7,457.60
Reitzel:	$9,416.80
Salazar:	$6,540.80

Finally, the investigative services are reduced as follows:

Gray:	$2,897 reduced to $2,032 (eliminate 5 hours of 17.5 hours).
Clement:	$3,070 reduced to $2,025 (eliminate five hours of 18 hours)
Salazar:	$3,344.50 reduced to $2,479.50 (eliminate five hours of 19.5 hours)
Reitzel:	$2,551.50 reduced to $1,686.50 (eliminate five hours of 15 hours)

After the appropriate reductions noted above, the total costs for the investigation and prosecution of the matter is $49,789.20. The amount attributed to each respondent is as follows:

Gray:	$9,303 + $2,032 = $11,335
Clement:	$8,848 + $2,025 = $10,873
Luckey:	$7,457.60
Reitzel:	$9,416.80 + $1,686.50 = $11,103.30
Salazar:	$6,540.80 + $2,479.50 = $9,020.30

20. It is determined that the above modified costs of investigation and prosecution of this matter are reasonable under section 125.3. However, the inquiry as to whether to impose these costs on respondents is governed by the California Supreme Court case of *Zuckerman v. Board of Chiropractic Examiners* (2002) 29 Cal.4th 32. *Zuckerman* sets forth the factors to be considered in determining the reasonableness of imposing costs on a chiropractor disciplined by the Board of Chiropractic Examiners. These factors should be applied to cost recovery schemes applicable to other governmental agencies.

The *Zuckerman* court held that "the Board must exercise its discretion to reduce or eliminate cost awards in a manner that will ensure that ... [cost recovery] does not deter chiropractors with potentially meritorious claims or defenses from exercising their right to a hearing." The court established five considerations that an agency must take into account when assessing the amount to be charged. The court said:

> [T]he Board must not assess the full costs of investigation and prosecution when to do so will unfairly penalize a chiropractor who has committed some misconduct but who has used the hearing process to obtain dismissal of other charges or a reduction in the severity of the discipline imposed. The Board must consider the chiropractor's "subjective good faith belief in the merits of his or her position" [Citation] and whether the chiropractor has raised a "colorable challenge" to the proposed discipline [Citation.] Furthermore, as in cost recoupment schemes in which the government seeks to recover from criminal defendants the cost of their state-provided legal representation [Citation] the Board must determine that the chiropractor will be financially able to make later payments. Finally the Board may not assess the full costs of investigation and prosecution when it has conducted a disproportionately large investigation and prosecution to

prove that a chiropractor engaged in relatively innocuous misconduct.[6]

In this matter, respondents were given the opportunity to apply the *Zuckerman* factors to their situations and to argue accordingly. *Gray, Clement and Reitzel* established that they had modest salaries and modest family incomes. Luckey established that she is retired, receiving a small pension and Social Security, and is working only intermittently at a modest wage.[7]

The remaining *Zuckerman* considerations are often intertwined. The agency must assess a respondent's "subjective good faith belief in the merits of [his or her] positions" and whether respondent "raised a colorable challenge to the proposed discipline." A related consideration is whether there has been some misconduct but the respondent has used the hearing process to obtain dismissal of other charges or a reduction in the severity of the discipline imposed.

Here, the Accusations sought revocation or suspension of licenses and imposition of costs.[8] As set forth below, respondents, with the exception of Salazar, were successful in obtaining a grant of probation rather than an outright revocation or suspension. At hearing, respondents raised a colorable challenge, not to whether there were grounds for discipline, but to whether revocation should be imposed, given the mitigation presented and given the passage of five and a half years since the incident. Additionally, both Reitzel and Salazar obtained dismissals of the charges of client abuse, mistreatment and excessive force.

Accordingly, given the financial portraits of Gray, Reitzel, Clement and Luckey, the grant of probation and these respondents' good faith belief that they had a sound defense of mitigation, the costs of investigation and prosecution of this matter are further reduced by one half for these respondents and they may pay costs in installment payments, as more fully set forth in the Order.

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[6] *Id.* at p. 45.

[7] One of the serious drawbacks of the *Zuckerman* case is that complainant is at a disadvantage in rebutting respondent's financial claims. Even if a bifurcated proceeding were instituted, wherein respondent was to produce proof of his or her financial position and complainant was permitted discovery, the cost of such a proceeding might very well exceed the costs sought in the underlying action.

[8] Another drawback in applying the *Zuckerman* factors is that the Evidence Code prohibits introduction of evidence of settlement offers. Thus, the finder of fact cannot go beyond the penalty sought in the pleadings in determining whether respondent has achieved a reduction of the severity of the discipline "imposed." Without information as to what discipline the agency has offered, it is impossible for the finder of fact to determine whether respondent "has used the hearing process to obtain ... a reduction in the severity of the discipline imposed."

ORDER

1. Psychiatric Technician License No. PT 19120 issued to EDWARD S. SALAZAR is REVOKED.

2. EDWARD S. SALAZAR shall pay the Bureau of Vocational Nurses and Psychiatric Technicians, or its designee, the sum of $9,020.30

3. Psychiatric Technician License No. PT 30932 issued to RICHARD LOYD GRAY is REVOKED. However, revocation is STAYED and a probationary license shall issue for three (3) years on the terms and conditions below.

4. Psychiatric Technician License PT 24049 issued to JANETTE LYNN CLEMENT is REVOKED. However, revocation is STAYED and a probationary license shall issue for three (3) years on the terms and conditions below.

5. Psychiatric Technician License PT 20539 issued to LAURINE P. LUCKEY is REVOKED. However, revocation is STAYED and a probationary license shall issue for three (3) years on the terms and conditions below.

6. Psychiatric Technician License PT 26367 issued to MARK STEVEN REITZEL is REVOKED. However, revocation is STAYED and a probationary license shall issue for three (3) years on the terms and conditions below.

CONDITIONS OF PROBATION

1. OBEY ALL LAWS

Each respondent shall obey all federal, state and local laws, including all statutes and regulations governing the license. Respondents shall submit, in writing, a full and detailed account of any and all violations of the law, including alleged violations, to the Board within five (5) days of occurrence.

To ensure compliance with this condition, respondents shall submit fingerprints through the Department of Justice and Federal Bureau of Investigation within thirty (30) days of the effective date of the decision, unless the Board determines that fingerprints were previously submitted by the respondents to the Board.

Each respondent shall also submit to the Board a recent 2" x 2" photograph of himself/herself within thirty (30) days of the effective date of the decision.

If a respondent is under a criminal court order, including probation or parole, and the order is violated, it shall be deemed a violation of these probation conditions.

2. COMPLIANCE WITH PROBATION PROGRAM

Each respondent shall fully comply with the conditions of probation established by the Board and shall cooperate with representatives of the Board in its monitoring and investigation of the respondents' compliance with the Probation Program.

Upon successful completion of probation, a respondent's license will be fully restored.

3. SUBMIT WRITTEN REPORTS

Each respondent shall submit or cause to be submitted, under penalty of perjury, any written reports, declarations and verification of actions as required by the Board or its representatives. These reports or declarations shall contain statements relative to respondents' compliance with all the conditions of the Board's Program. Respondents shall immediately execute all release of information forms as may be required by the Board or its representatives.

In the first report, each respondent shall provide a list of all states and territories where he/she has ever been licensed as a vocational/practical nurse, psychiatric technician, or registered nurse. Each respondent shall provide information regarding the status of each license and any change in license status during the period of probation. Each respondent shall inform the Board if he/she applies for or obtains a new nursing or psychiatric technician license during the period of probation.

Each respondent shall provide a copy of the Board's decision to the regulatory agency in every state and territory in which he/she has applied for or holds a vocational/practical nurse, psychiatric technician and/or registered nurse license.

4. NOTIFICATION OF ADDRESS AND TELEPHONE NUMBER CHANGE(S)

Each respondent shall notify the Board, in writing, within five (5) days of any change in address or telephone number(s).

A respondent's failure to claim mail sent by the Board may be deemed a violation of these probation conditions.

5. NOTIFICATION OF RESIDENCY OR PRACTICE OUTSIDE OF STATE

Each respondent shall notify the Board, in writing, within five (5) days, if he/she leaves California to reside or practice in another state. Periods of residency or practice outside of California shall not apply toward a reduction of this probation time period. If respondent resides or practices outside of California, the period of probation shall be automatically extended for the same time period he/she resides or practices outside of California. Each respondent shall provide written notice to the Board within five (5) days of any change of residency or practice.

Each respondent shall notify the Board, in writing, within five (5) days, upon his/her return to California.

6. MEETINGS WITH BOARD REPRESENTATIVE(S)

Each respondent shall appear in person at meetings as directed by the Board or its designated representatives.

7. NOTIFICATION TO EMPLOYER(S)

When currently employed or applying for employment in any capacity in any health care profession, respondent shall notify his/her employer of the probationary status of respondents' license. This notification to the respondents' current health care employer shall occur no later than the effective date of the Decision. Respondent shall notify any prospective health care employer of his/her probationary status with the Board prior to accepting such employment. At a minimum, this notification shall be accomplished by providing the employer or prospective employer with a copy of the Board's Accusation and Disciplinary Decision.

The Health Care Profession includes, but is not limited to: Licensed Vocational Nurse, Psychiatric Technician, Registered Nurse, Medical Assistant, Paramedic, Emergency Medical Technician, Certified Nursing Assistant, Home Health Aide, and all other ancillary technical health care positions.

Each respondent shall cause each health care employer to submit to the Board all performance evaluations and any other employment related reports as required by the Board. Each respondent shall notify the Board, in writing, of any difficulty in securing employer reports within five (5) days of such an event.

Each respondent shall notify the Board, in writing, within five (5) days of any change in employment status. Each respondent shall notify the Board, in writing, if he/she is terminated or separated, regardless of cause, from any nursing or health care related employment with a full explanation of the circumstances surrounding the termination or separation.

8. EMPLOYMENT REQUIREMENTS AND LIMITATIONS

Respondents, Gray, Reitzel and Clement shall work in his/her licensed capacity in the state of California. This practice shall consist of no less than six (6) continuous months and of no less than twenty (20) hours per week.

Respondent Luckey shall work in his/her licensed capacity in the state of California. If Luckey wishes to remain retired, she and the Board shall establish a minimum level of hours of employment to allow her to meet this requirement.

Respondents shall not work for a nurses' registry or in any private duty position, a temporary nurse placement agency, as a faculty member in an accredited or approved school of nursing, or as an instructor in a Board approved continuing education course except as approved, in writing, by the Board. Respondents shall work only on a regularly assigned, identified and predetermined work site(s) and shall not work in a float capacity except as approved, in writing, by the Board.

Respondent Luckey may remain in the capacity as a retired annuitant serving the PDC.

9. SUPERVISION REQUIREMENTS

Before commencing or continuing employment in any health care profession, each respondent shall obtain approval from the Board of the supervision provided to the respondents while employed.

Respondents shall not function as a charge nurse (i.e., work in any healthcare setting as the person who oversees or directs licensed vocational nurses, psychiatric technicians, certified nursing assistants or unlicensed assistive personnel) or supervising psychiatric technician during the period of probation except as approved, in writing, by the Board.

10. COMPLETION OF EDUCATIONAL COURSE(S)

Each respondent, at his or her own expense, shall enroll and successfully complete a course(s) substantially related to the violation(s) no later than the end of the first year of probation. One of the courses respondents shall enroll in and complete shall be a course which focuses on ethics and integrity.

The coursework shall be in addition to that required for license renewal. The Board shall notify the respondents of the course content and number of contact hours required. Within thirty (30) days of the Board's written notification of assigned coursework, respondents shall submit a written plan to comply with this requirement. The Board shall approve such plan prior to enrollment in any course of study.

Upon successful completion of the course, respondents shall submit "original" completion certificates to the Board within thirty (30) days of course completion.

11. MAINTENANCE OF VALID LICENSE

Each respondent shall, at all times, maintain an active current license with the Board including any period of suspension.

If an initial license must be issued (Statement of Issues) or a license is reinstated, probation shall not commence until a license is issued by the Board. Respondents must complete the licensure process within two (2) years from the effective date of the Board's decision.

Should a respondent's license expire, by operation of law or otherwise, upon renewal or reinstatement, respondent's license shall be subject to any and all conditions of this probation not previously satisfied.

12. COST RECOVERY REQUIREMENTS

Respondents shall pay to the Board costs associated with its investigation and enforcement pursuant to Business and Professions Code section 125.3, the amounts that follow.

Gray:	$5,667.50
Clement:	$5,436.50
Luckey:	$3,728.80
Reitzel:	$5,551.65

Respondents shall be permitted to pay these costs in a payment plan approved by the Board with payments to be completed no later than three months prior to the end of the probation period. The filing of bankruptcy by a respondent shall not relieve respondent of his/her responsibility to reimburse the Board for its investigation and prosecution costs. Failure to make payments in accordance with any formal agreement entered into with the Board or pursuant to any Decision by the Board shall be considered a violation of probation.

If a respondent has not complied with this condition during the probationary period, and respondent presents sufficient documentation of his/her good faith effort to comply with this condition, and if no other conditions have been violated, the Board or its representatives may, upon written request from the respondent, extend the probation period up to one year, without further hearing, in order to comply with this condition. During the extension, all original conditions of probation will apply.

Except as provided above, the Board shall not renew or reinstate the license of any respondent who has failed to pay all the costs as directed in a Decision.

13. LICENSE SURRENDER

During probation, if a respondent ceases practicing due to retirement, health reasons, or is otherwise unable to satisfy the conditions of probation, respondent may surrender his/her license to the Board. The Board reserves the right to evaluate respondent's request and to exercise its discretion whether to grant the request without further hearing. Upon formal acceptance of the tendered license, respondents will no longer be subject to the conditions of probation.

Surrender of a respondent's license shall be considered a disciplinary action and shall become a part of respondents' license history with the Board. A licensee who surrenders his/her license may petition the Board for reinstatement no sooner than the following minimum periods from the effective date of the disciplinary decision for the surrender:

Three (3) years for reinstatement of a license surrendered for any reason other than a mental or physical illness; or
One (1) year for a license surrendered for a mental or physical illness.

14. VIOLATION OF PROBATION

If a respondent violates the conditions of his/her probation, the Board, after giving the respondent notice and an opportunity to be heard, may set aside the stay order and impose the stayed discipline (denial/revocation) of the respondent's license. If during probation, an accusation or petition to revoke

probation has been filed against a respondent's license or the Attorney General's Office has been requested to prepare an accusation or petition to revoke probation against a respondent's license, the probationary period shall automatically be extended and shall not expire until the accusation or petition has been acted upon by the Board.

Dated: November 26, 2008

ANN ELIZABETH SARLI
Administrative Law Judge
Office of Administrative Hearings

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Attorneys for Complainant

BEFORE THE
BOARD OF VOCATIONAL NURSING AND PSYCHIATRIC TECHNICIANS
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: RICHARD LOYD GRAY 285 S. Red Oak Street Porterville, CA 93257 Psychiatric Technician License No. PT 30932 Respondent.	Case No. PT-2003-1249 **ACCUSATION**

Complainant alleges:

PARTIES

1. Teresa Bello-Jones, J.D., M.S.N., R.N. (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Vocational Nursing and Psychiatric Technicians, Department of Consumer Affairs.

2. On or about May 14, 2001, the Board of Vocational Nursing and Psychiatric Technicians issued Psychiatric Technician License Number PT 30932 to Richard Loyd Gray (Respondent). The Psychiatric Technician License was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2009, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board of Vocational Nursing and Psychiatric Technicians (Board), Department of Consumer Affairs, under the authority of the

following laws. All section references are to the Business and Professions Code unless otherwise indicated.

STATUTORY and REGULATORY PROVISIONS

4. Section 4520 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensed psychiatric technician for any reason provided in Article 3 (commencing with section 4520) of the Psychiatric Technicians Law (Code § 4500, et. seq.)

5. Section 118(b) of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated. Under section 4545 of the Code, the Board may renew an expired license at any time within four years after the expiration.

6. Section 4521 of the Code states:

"The board may suspend or revoke a license issued under this chapter [the Psychiatric Technicians Law (Bus. & Prof Code, 4500, et seq.)] for any of the following reasons:

"(a) Unprofessional conduct, which includes but is not limited to any of the following:

(1) Incompetence or gross negligence in carrying out usual psychiatric technician functions.

. . .

(d) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate any provision or terms of this chapter.

. . .

(i) The use of excessive force upon or the mistreatment or abuse of any patient. . . ."

7. California Code of Regulations, title 16, section 2576.5, states:

"The licensed psychiatric technician performs services requiring technical and manual skills which include the following:

(a) Uses and practices basic assessment (data collection), participates in planning, executes interventions in accordance with the care plan or treatment plan, and contributes to evaluation of individualized interventions related to the care plan or treatment plan.

(b) Provides direct patient/client care by which the licensee:

(1) Performs basic nursing services as defined in subdivision (a);

(2) Administers medications;

(3) Applies communication skills for the purpose of patient/client care and education; and

(4) Contributes to the development and implementation of a teaching plan related to self-care for the patient/client."

8. California Code of Regulations, title 16, section 2576.6, states:

"(a) A licensed psychiatric technician shall safeguard patients'/clients' health and safety by actions that include but are not limited to the following:

(1) Reporting to the Board acts specified in Section 4521 of the Business and Professions Code;

(2) Documenting patient/client care in accordance with standards of the profession; and

(3) Performing services in accordance with Section 125.6 of the Business and Professions Code.

(b) A licensed psychiatric technician shall adhere to standards of the profession and shall incorporate ethical and behavioral standards of professional practice which include but are not limited to the following:

(1) Maintaining current knowledge and skills for safe and competent practice;

(2) Maintaining patient/client confidentiality;

(3) Maintaining professional boundaries with the patient/client;

(4) Abstaining from chemical/substance abuse; and

(5) Cooperating with the Board during investigations as required by Section 4521.2 of the Business and Professions Code.

(c) A violation of this section constitutes unprofessional conduct for purposes of initiating disciplinary action."

9. California Code of Regulations, title 16, section 2577, states:

"As set forth in Section 4521 of the code, gross negligence is deemed unprofessional conduct and is grounds for disciplinary action. As used in Section 4521 'gross negligence' means a substantial departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent licensed psychiatric technician, and which has or could have resulted in harm to the consumer. An exercise of so slight a degree of care as to justify the belief that there was a conscious disregard or indifference for the health, safety, or welfare of the consumer shall be considered a substantial departure from the above standard care."

10. California Code of Regulations, title 16, section 2577.1, states:

"As set forth in Section 4521 of the code, incompetence is deemed unprofessional conduct and is grounds for disciplinary action. As used in Section 4521, 'incompetence' means the lack of possession of and the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by responsible licensed psychiatric technicians."

COST RECOVERY

11. Section 125.3 of the Code provides, in pertinent part, that a Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

STATEMENT OF FACTS

12. In April 2003, client A.M.[1] was a 37 year old, developmental disabled, resident on Unit 17 at Porterville Developmental Center (PDC). Client A.M. was approximately six feet tall and weighed approximately 250 pounds. Client A.M. was deaf and mute, but could

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1. In order to protect the privacy of the client and his family, only the initials of the client will be used in this document.

read lips. He was diagnosed with paranoid schizophrenia and mild mental retardation. While a resident at PDC, Client A.M. had a history of engaging in various dangerous and disturbing behaviors due to his unstable mental status.

Licensed psychiatric technicians and psychiatric technician assistants employed at PDC are instructed in Active Treatment Crisis Management (ATCM). ATCM training teaches employees how to handle aggressive and/or assaultive clients. If a client assaults staff, employees at PDC are to "escape, evade and get help." In a crisis situation, an escape and evade response may escalate into a physical intervention or "containment" of the client. Pursuant to PDC policies and procedures, there are no one-person containment procedures. The minimum number to staff required to "contain" a client is two staff members, and the maximum number is five staff members. Respondent had been trained in both ATCM protocols and in PDC policies on "containments."

In April 2003, Client A.M. exhibited an pattern of escalating behavior and refusal to take routine medication. On April 13, 2003, Client A.M. became angry and upset. Client A.M. took the keys of a PDC staff member and stabbed the staff member in the stomach with one of the keys. This was reported to Respondent. Respondent activated his alarm and pursued Client A.M. Respondent initiated and attempted to "contain" Client A.M through the use of a one person containment. Respondent was attempting to contain Client A.M. by lying on the back of the struggling client. Respondent placed his arm around Client A.M.'s neck. This was not an approved ATCM containment procedure.

Two PDC staff members arrived in response to Respondent's alarm. Even though the additional staff members were attempting to contain the arms of Client A.M., Respondent continued to lay across the client's back with his arm around Client A.M.'s neck. Respondent then proceeded to pull the upper body of Client A.M. off the floor, while still positioned on the Client's back and with his arm around Client A.M.'s neck, in an attempt to apply restraints. This was not the correct procedure for the application of restraints.

After several minutes of attempting to "contain" Client A.M., the Client eventually stopped struggling. Client A.M. died. The medical examiner determined that the

cause of Client A.M.'s death was "Cardiac dysrhythmia due to prolonged left carotid artery compression."

FIRST CAUSE FOR DISCIPLINE

(Incompetence and/or Gross Negligence)

13. Respondent is subject to disciplinary action under Code section 4521, subdivision (a)(1), as defined by California Code of Regulations, title 16, sections 2576.5, 2576.6, 2577 and 2577.1, on the grounds of incompetence and/or gross negligence, in that Respondent departed from, and/or substantially departed from, the standard of care ordinarily possessed and exercised by a responsible licensed psychiatric technician. The circumstances are as follows:

a. On or about April 13, 2003, Respondent failed to follow proper procedures of ATCM and the policies and procedures of PDC when he initiated an improper and unsafe one person "containment" of Client A.M., as more fully set forth in paragraph 12, above.

b. On or about April 13, 2003, Respondent failed to ensure the safety of Client A.M. by placing his arm around the client's neck, as more fully set forth in paragraph 12, above.

SECOND CAUSE FOR DISCIPLINE

(Use of Excessive Force / Mistreatment / Abuse)

14. Respondent is subject to disciplinary action under Code section 4521, subdivision (i), in that on about April 13, 2003, Respondent used excessive force, mistreated, and/or abused Client A.M., as more fully set forth in paragraphs 12 and 13, above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Vocational Nursing and Psychiatric Technicians issue a decision:

1. Revoking or suspending Psychiatric Technician License Number PT 30932, issued to Richard Loyd Gray.

2. Ordering Richard Loyd Gray to pay the Board of Vocational Nursing and

Psychiatric Technicians the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: February 7, 2008

TERESA BELLO-JONES, J.D., M.S.N., R.N.
Executive Officer
Board of Vocational Nursing and Psychiatric Technicians
Department of Consumer Affairs
State of California
Complainant

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